IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to correctly and fully complete this form may result in delay or denial of licensure.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

The following materials are required to review Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the names shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.
B. This licensure and application fee are NOT refundable.
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment of tax, penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue.

Chicago

A. SEE REFERENCE SHEET, CHART I, ON INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	1 2 5	NON-EXAMINATION	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: _____
- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under a new name/surname.

PART II - [illegible] you [illegible] Department of [illegible] otherwise specified, all items must be completed.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Garcia	Anthony	Joseph	M.D.	

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

1819 W. Polk Room 446 Chicago IL 60612-7335

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED (SEE INSTRUCTIONS #5 ABOVE)

N/A

7. PLACE OF BIRTH CITY STATE/COUNTRY 8. DATE OF BIRTH 9. AGE

[ ] Female [X] Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (AREA CODE) Home: (AREA CODE)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)
1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? ☒ Yes ☐ No OR G.E.D.? ☐ Yes ☒ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION Month / Year
Walnut High School	Walnut, CA	06 / 1991

5. COLLEGE OR UNIVERSITY (Circle number of years completed)
1 2 3 4 5 6 7 8 Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	DATES OF ATTENDANCE TO Month/Year	TYPE OF DEGREE EARNED
California State University Los Angeles	Los Angeles, CA	06/90	06/94	B.S.
University of Utah	Salt Lake City, UT	8/94	5/99	M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	DATES OF ATTENDANCE TO Month/Year	Did You Complete Training?
Creighton University	Omaha, NE	7/2000	7/2001	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Garcia, Anthony J. Physician

Garcia, Anthony, T. [redacted] Physician

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Nebraska	Physician	4214	7/2000	Lapsed
State of Current Licensure where you most recently have been practicing:				
Other States of Licensure:				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Honors)
USMLE Step 1	UT	6/97	Failed
USMLE Step 1	CA	10/97	Passed
USMLE Step 2	CA	8/98	Failed
USMLE Step 2	CA	3/99	Passed
USMLE Step 3	CA	2/2000	Passed

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI) Gaccia, Anthony, T SS#

PART V: Personal History Information (This part must be completed by all applicants)	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X

PART VI: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes:

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? Yes ☐ No ☐

PART VII: Child Support Information *(This part must be completed by all applicants)*

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order.

Are you more than 30 days delinquent in complying with a child support order?
(NOTE: If you are not subject to a child support order, answer "no.")

☒ NO ☐ Yes

In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.

PART VIII: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 7-18-2001

Signature of Applicant Date

My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Physician

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before the [illegible] Department of Professional Regulation, without notice of the approval of his application.

APPLICANT: Complete this [illegible] section of this form, then forward it to the [illegible] for [illegible] residency training. For completion of the [illegible]

1. NAME — LAST: GARCIA, FIRST: ANTHONY, MIDDLE: J.
2. DATE OF BIRTH [redacted]
3. SOCIAL SECURITY NUMBER [redacted]
4. ADDRESS: STREET, CITY, STATE, ZIP CODE
5. MAIDEN OR GIVEN SURNAME
6. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making [illegible]

PHYSICIAN — Profession Name — 1 2 5 — Profession Code

7. ADMINISTRATOR: Complete [illegible] of this form to [illegible]

A. HOSPITAL/INSTITUTION NAME: UNIVERSITY OF ILLINOIS-CHICAGO

B. BEGINNING DATE: 09 (Month) 01 (Day) 2001 (Year)

C. ENDING DATE: 08 (Month) 31 (Day) 2004 (Year)

D. BUSINESS ADDRESS: STREET, CITY, STATE, ZIP CODE: 914 S. WOOD ST., (MC 675) CHICAGO, IL 60612

E. SPECIALTY / RESIDENCY NAME: PATHOLOGY

F. BUSINESS TELEPHONE NUMBER: Area Code (3 1 2) 9 9 6 – 2 9 3 3

G. YEAR OF POSTGRADUATE TRAINING: 2

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

RECEIVED
AUG 27 2001
IDPR-MEDICAL UNIT

[redacted]
Signature of Program Director

WELLINGTON JAO, M.D.
Print Name of Program Director

PROGRAM DIRECTOR
Title

8/13/01
Date

SEAL

IL455-0272 10/95 (MD)

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

September 12, 2001

Anthony Joseph Garcia, MD
[redacted]

Dear Dr. Garcia:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 09/01/2001. Assuming you remain in the training program listed below, this license will be valid until 08/31/2004.

PROGRAM: Pathology Training
TRAINING FACILITY: Univ of Il @ Chgo Hosp

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program, i.e. "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Alicia Purchase, Manager
Medical Unit

RC: lv3 125

TEMPORARY CHECKLIST 125___ 130___

APPLICATION FINDING

- ✓ Application Complete
- ✓ Personal History Yes#_____
- N/A CA-MED(125)
  - Start Date: 9-1-01
  - End Date: 8-31-04
  - Program: Pathology
- ___CA-LTD(130) - Illinois Program
  - Start Date:_____
  - End Date:_____
  - Program:_____
- ___CA-MED(130) - Out-of-State Program

PERSONAL HISTORY DOCUMENTS

UNIVERSITY OF ILLINOIS HOSPITAL/CHICAGO
Dept of GME
914 South Wood Street MC 675
Chicago 60612
Phone: 312/996-1068

DOMESTIC GRADUATES

- N/A ED-MED or Roster Date_____
- ✓ Medical Transcripts
- N/A Premedical Transcripts
- N/A Diploma Date 5-22-99

FOREIGN GRADUATES

- ___ECFMG/5th Pathway/Social Service
- ___Premedical Transcripts ___Translations
- ___Medical Transcripts ___Translations
- ___Diploma Date_____ ___Translation
- ___AF-MED Part A
- ___AF-MED Part B
- ___INTERNAL MED: Evaluation ___
  - Hospital:_____
  - Agreement___
  - Affidavits: Hospital___School___
- ___PEDIATRICS: Evaluation ___
  - Hospital:_____
  - Agreement___
  - Affidavits: Hospital___School___
- ___SURGERY: Evaluation ___
  - Hospital:_____
  - Agreement___
  - Affidavits: Hospital___School___
- ___OB/GYN: Evaluation ___
  - Hospital:_____
  - Agreement___
  - Affidavits: Hospital___School___
- ___PSYCHIATRY: Evaluation ___
  - Hospital:_____
  - Agreement___
  - Affidavits: Hospital___School___

___ED-NON _____Total months -must be minimum of 36 w/premed; 54 combined.
Minimum 4-weeks in Core Rotations: ___Med ___Ob/Gyn ___Peds ___Psych ___Surgery
Psychiatry Affidavit if only 2-weeks verified_____

SUPPORTING DOCUMENTS

- ✓ Work History Clinical Skills OK N/A
- N/A Original Jurisdiction of Licensure
  - License State & Number 4214-Alabama N/A No Discipline ✓
- N/A Current Jurisdiction of Licensure
  - License State & Number_____ No Discipline_____
- N/A Name Change
- ✓ Federation Check

#125-043786
Approved 9-12-01

Profession: 125
Date: 8-8-01 Initials: TF

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO: Anthony J. Garcia, MD

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

	1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part _____
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.
	4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).
	5. Submit proof that you are a lawfully admitted alien.
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on _____.
X	9. Submit completed CA-IMED form which indicates beginning and ending program dates.
	10. Submit CA-LTD form.
X	11. Submit ED-IMED form (certification of education).
	12. Submit ED-HON form completed in its entirety.
	13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.
X	14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.
X	15. Submit official premedical/medical transcript with school seal affixed.
X	16. Submit photocopy of your degree.
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____
	21. Complete AF-IMED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WE).
X	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	28. Have your _____ scores forwarded directly from _____.
	29. Submit evidence of remedial training.
	30. Submit TH-IMED form signed by program director, with seal of hospital.
X	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
X	33. Submit certification of original/current licensure (Supporting Document CT) from Nebraska
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other Instructions:

IL426-1598 5/94 (LT)

09/02/99 **UNIVERSITY OF UTAH** PAGE 01

SALT LAKE CITY, UTAH 84112

ACADEMIC RECORD OF

NAME: GARCIA, ANTHONY JOSEPH

SSN: [redacted]

DEGREES AWARDED BY OTHER INSTITUTIONS

JUN BACHELOR SCIENCE

CALIFORNIA STATE UNIV LOS ANGELES

1990 LOS ANGELES CA

US

CUMULATIVE UNIVERSITY OF UTAH GPA 0.00

UNIVERSITY OF UTAH COURSE UNITS PASSED 226.0

U OF U UNITS IN CUMULATIVE GPA CALCULATION 0.0

TOTAL UNITS PASSED (INCLUDING TRANSFER CREDIT 226.0

SPECIAL EXAM ETC

COURSE TITLE	DEPT	CRSE	LE	UNIT	GR
***** BEGINNING OF GRADUATE ACADEMIC RECORD *****					
AUTUMN 1994					
GROSS ANATOMY HUMAN	ANAT	601			
HISTOLOGY	ANAT	603			
EMBRYOLOGY	ANAT	606			
MEDICAL BIOCHEMISTRY	BIO C	608			
QUARTER UNITS PASSED 25.0 TERM GPA					
WINTER 1995					
MEDICAL BIOCHEMISTRY	BIO C	609			
MEDICINE & SOCIETY	FP MD	634			
MEDICAL PHYSIOLOGY	PHYSL	603			
BASIC SCI FOUNDATION	PSYCT	601			
QUARTER UNITS PASSED 23.0 TERM GPA					
SPRING 1995					
MEDICAL BIOCHEMISTRY	BIO C	610			
GENETICS IN MEDICINE	H GEN	610			
ENDOCRINOLOGY	PHYSL	604			
***** CONTINUED NEXT COLUMN *****					

COURSE TITLE	DEPT	CRSE	LE	UNIT	GR
QUARTER UNITS PASSED 6.0 TERM GPA 0.00					
AUTUMN 1995					
CPR RECERTIFICATON	H EDU	47		0.0	
NON DEGREE CREDIT					
MEDICAL IMMUNOLOGY	PATH	600			
MEDICAL MICROBIOLOGY	PATH	604			
QUARTER UNITS PASSED 9.0 TERM GPA 0.00					
SPRING 1996					
NEUROANATOMY	ANAT	605			
INTRO TO MEDICINE	INTMD	701			
QUARTER UNITS PASSED 10.0 TERM GPA 0.00					
AUTUMN 1996					
INTRO TO MEDICINE	INTMD	702			
GENERAL PATHOLOGY	PATH	601			
PHARMACOLOGY THERAPY	PH TX	601			
QUARTER UNITS PASSED 18.0 TERM GPA 0.00					
WINTER 1997					
ORGAN SYSTEMS	MD ID	603			
SYSTEMIC PATHOLOGY	PATH	602			
PHARMACOLOGY	PH TX	604			
QUARTER UNITS PASSED 23.0 TERM GPA 0.00					
SPRING 1997					
FOUNDATIONS GERIATRICS	INTMD	704			
ORGAN SYSTEMS	MD ID	603			
SYSTEMIC PATHOLOGY	PATH	603			
INTRO CLINICAL PSYCHIATR	PSYCT	610			
QUARTER UNITS PASSED 21.0 TERM GPA 0.00					

***** CONTINUED PAGE 02 *****

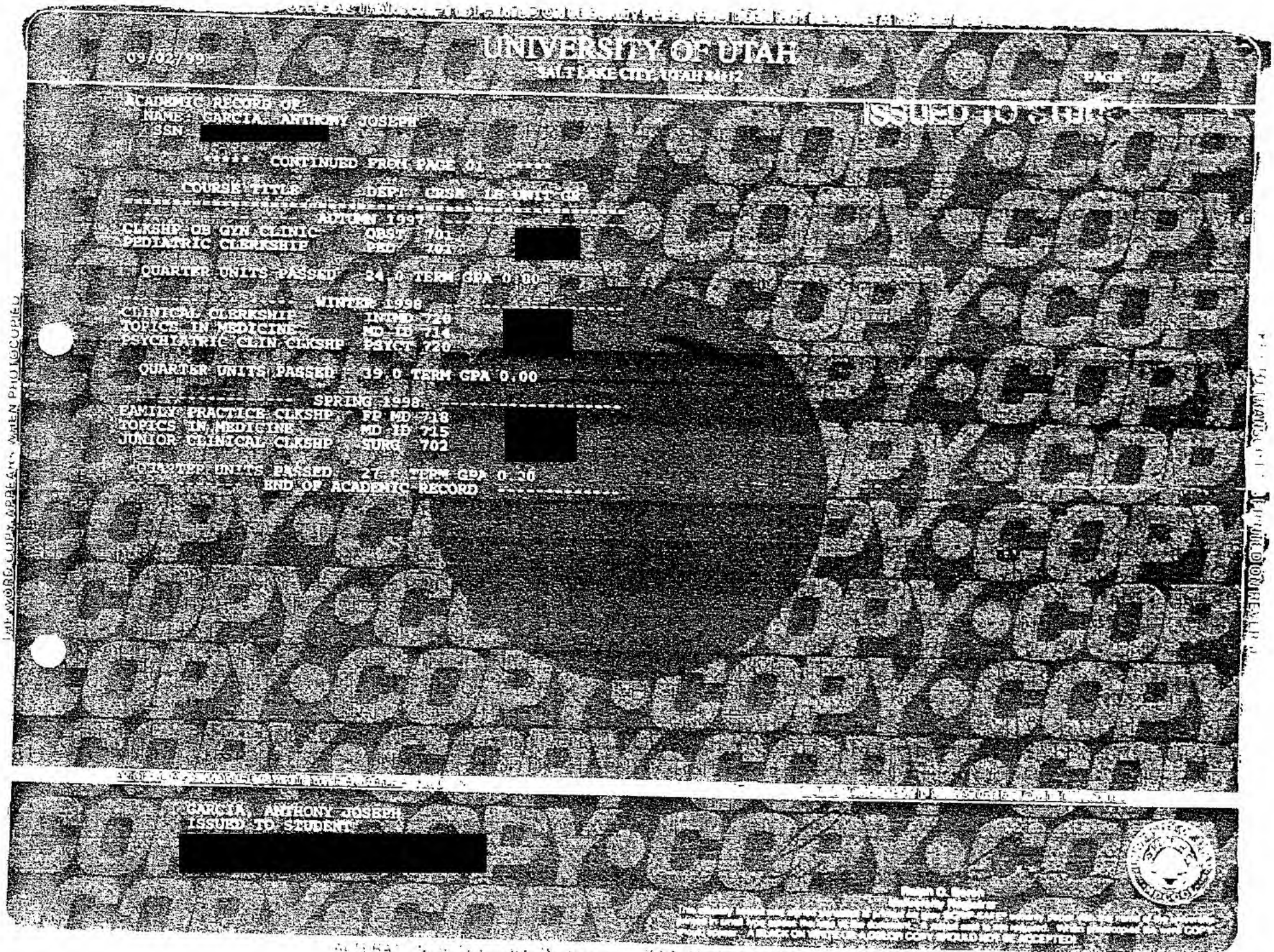
TO TRANSCRIPT REQUEST CONTINUED

GARCIA, ANTHONY JOSEPH

ISSUED TO STUDENT [redacted]

Page 1

Copy



09/02/99

UNIVERSITY OF UTAH

SALT LAKE CITY, UTAH 84112-1107

PAGE 02

ACADEMIC RECORD OF:
NAME: GARCIA, ANTHONY JOSEPH
SSN: [redacted]

ISSUED TO STUDENT

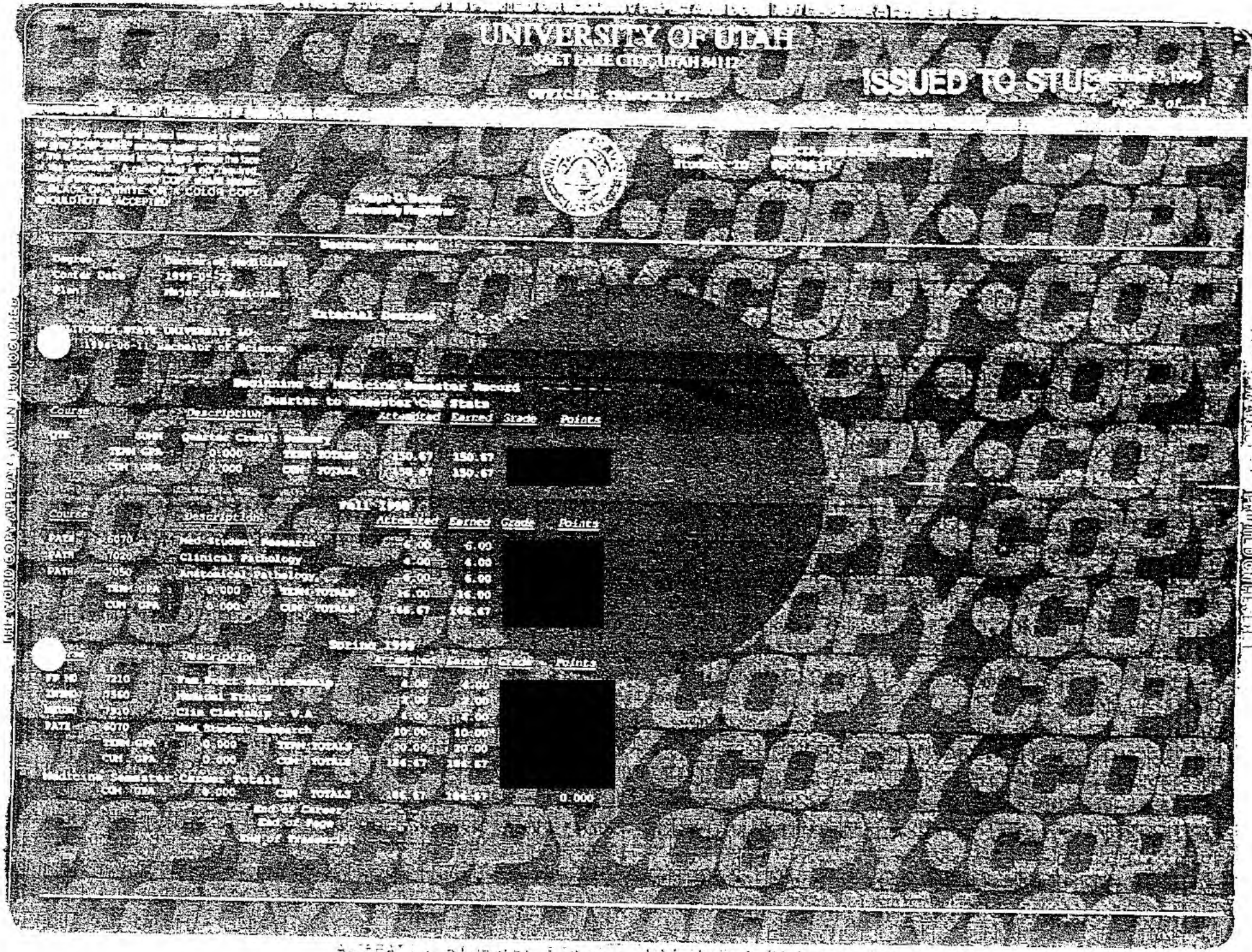
**** CONTINUED FROM PAGE 01 ****

COURSE	TITLE	DEPT	CRSE	SEC	UNIT	GR
	AUTUMN 1997					
CLKSHP OB GYN CLINIC		OBGY	701			
PEDIATRIC CLERKSHIP		PED	707			
QUARTER UNITS PASSED	24.0	TERM GPA	0.00			
	WINTER 1998					
CLINICAL CLERKSHIP		INTMD	720			
TOPICS IN MEDICINE		MD ID	714			
PSYCHIATRIC CLIN CLKSHP		PSYCT	720			
QUARTER UNITS PASSED	19.0	TERM GPA	0.00			
	SPRING 1998					
FAMILY PRACTICE CLKSHP		FP MD	718			
TOPICS IN MEDICINE		MD ID	715			
JUNIOR CLINICAL CLKSHP		SURG	702			
QUARTER UNITS PASSED	27.0	TERM GPA	0.00			

END OF ACADEMIC RECORD

GARCIA, ANTHONY JOSEPH
ISSUED TO STUDENT
[redacted]

UNIVERSITY OF UTAH


UNIVERSITY OF UTAH
ISSUED TO STUD

The University of Utah

upon the recommendation of the Faculty of

The School of Medicine

has conferred upon

Anthony Joseph Garcia

the Degree of

Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Thereof we have caused the Seal of the University to be affixed this

Twenty-second day of May, One Thousand Nine Hundred Ninety-nine.

[redacted]

[redacted]

[redacted]

[redacted]

0083107 00282 (40 40)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME — LAST: Garcia, FIRST: Anthony, MIDDLE: Joseph

2. DATE OF BIRTH: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Profession Name: Physician — Profession Code: 1 a 5

6. MAIDEN OR GIVEN SURNAME: N/A

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐

8. DATE FORM COMPLETED: 7-18-2001

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION: Creighton University
ADDRESS STREET, CITY, STATE, ZIP CODE: 601 N. 30th St. Omaha, NE. 68131
SUPERVISOR NAME: William Hunter
DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2000 (Month/Day/Year) To 07/31/2001
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 1 year
JOB TITLE: Physician
DESCRIPTION OF DUTIES PERFORMED: Anatomic and clinical Pathology
Study Pathology
Study Medicine
Job seeking

B. NAME OF BUSINESS / INSTITUTION: Anthony Garcia
ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]
SUPERVISOR NAME: Anthony Garcia
DATE OF EMPLOYMENT/ATTENDANCE: From 05/23/1999 (Month/Day/Year) To 06/30/2000
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 1 year 1 month
JOB TITLE: Physician / Studier
DESCRIPTION OF DUTIES PERFORMED: Study for USMLE Step3
Study Pathology
Study Medicine
Job seeking

NAME (Last, First, MI) Garcia, Anthony, T. SS#

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination

(Record all available information)

Scaled Score		Raw Score	
Standard Deviation		Corrected Score	
National Mean		Percent Score	

A2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? Yes ☐ No ☐

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☐ No

PART V - RECIPROCAL REGISTRATION

This state ☐ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL

Print Name

Title

Signature

Agency/Board Street Address

Date

Area Code ( )

City, State, ZIP Code

Telephone Number

RETURN NONEXAM CT TO: Department of Professional Regulation
320 West Washington, L & T-1
Springfield, Illinois 62786

Physician

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

CERTIFICATION OF LICENSE

State of Illinois
Dept of Professional Regulation
320 W Washington St
Springfield IL 62786

PROFESSION NAME: Temporary Educational Permit

Number: 4214
Issuance Date: 07/01/2000
Status: Active
Expiration Date: 07/01/2002

Name: Anthony Joseph Garcia MD
Address: Creighton - Pathology
[redacted]

Credential Obtained by: Application

School/Graduation Date: Univ of Utah School of Med - Salt Lake City 05/22/1999

Date of Birth: [redacted]
Place of Birth: California

Disciplinary Action:

To expedite the certification process, the Credentialing Division is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

[redacted]

Helen L. Meeks, Administrator
Credentialing Division

August 28, 2001

(SEAL)

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You may verify licenses under the following Internet Web Site Address:
http://www.hhs.state.ne.us/lis/lis.asp

DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE
PO BOX 95007, LINCOLN, NE 68509-5007 PHONE (402) 471-2133

The Federation of State Medical Boards
of the United States, Inc.
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

August 07, 2001

Attn: Alicia Purchase
Illinois Dept. of Reg. & Ed.
320 W. Washington Street
Springfield, IL 62786

Re: Board Action Query Dated: August 07, 2001
Your Reference Number:
FSMB Batch Number: [redacted]

The following is a final report of the search results from the Board Action Data Bank as of August 07, 2001 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of August 07, 2001

Item	Name	DOB	SSN	School	Yr/Grad	Request ID
6	DACANAY, KAREN	[redacted]	[redacted]	748070	1998	[redacted]
7	GARCIA, ANTHONY			045010	1999	
8	GOODMAN, KATHY			049020	1987	
9	MELAMED, HOOMAN			039070	1999	
3	PANNARALLA, AMY			016020	1998	
4	STEPHEN, CATHLYN			014060	1987	
5	THOMAS, ANDREA			099680	2000	

20031070028214040

CREDENTIALING DIVISION
JUL 19 2001
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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT
CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME: LAST: Garcia FIRST: Anthony MIDDLE: Joseph
2. DATE OF BIRTH
3. SOCIAL SECURITY NUMBER
4. ADDRESS: STREET, CITY, STATE, ZIP CODE
5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Profession Name: Physician
Profession Code: 1 2 5
6. GIVEN SURNAME: N/A.
7. APPLICANT TELEPHONE NUMBER (Daytime)
Area Code (
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)
8b. LICENSE NUMBER (If applicable): 4214
8c. ISSUANCE DATE OF LICENSE (If applicable): 07/01/2000

I hereby authorize Dept. of Health and Human Services to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.
Name of Licensing Agency or Board

Signature [redacted] - M.D. Date 7-18-2001

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

Name of Examination _____ Date of Examination _____

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE
B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE
D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD
- ☐ Examination (Administered in Your State)
  - ☐ National (Name) _____
  - ☐ State Constructed _____
  - ☐ Other (Name) _____
- ☐ Endorsement of License (State) _____
- Acceptance of Examination Results (Administered in Another State) _____
- ☐ Reciprocity with (State) _____
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS
- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	
Practical	
Other (Describe) _____	

Received no Grade Below _____
Examination Period _____ days _____ hours

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
5151 STATE UNIVERSITY DRIVE, LOS ANGELES, CA 90032

Anthony J. Garcia

Student ID: [redacted] Birthdate: [redacted]

Official Baccalaureate Academic Record

Secondary Schools:
High School Graduation Date — Graduated Jun 1991

Higher Education Institutions:

UC Davis	Sep 1993 - Dec 1993
CSU Los Angeles	Jun 1992 - Sep 1993
Mt San Antonio College	Jun 1988 - Jun 1992
CSU Cal Poly Pomona	Jan 1991 - Jun 1992
Prelim Last 90	

Degrees Awarded:
Bachelor of Science — Jun 11, 1994
School of Natural & Social Sciences
Major: Biology

Transfer Credit:
HIGHER EDUCATION CREDIT: 136.00

Summer Quarter 1992

BIOL-418	EVOLUTION
BIOL-499	UNDRGRD DIR STUDY
	Credit/No Credit

	AHRS	EHRS	QHRS
Current	8.00	8.00	4.00
Cumulative	144.00	144.00	4.00

Fall Quarter 1992

BIOL-360	GENERAL ECOLOGY
BIOL-398	COOP EDUC
	Credit/No Credit
CHEM-201	QUANT ANALYSIS
CHEM-301A	ORGANIC CHEMISTRY
SOC -425	MEDICAL SOCIOLOGY

	AHRS	EHRS	QHRS
Current	18.00	18.00	16.00
Cumulative	162.00	162.00	20.00

Winter Quarter 1993

BIOL-330	CELL BIOLOGY
BIOL-357	WRITING FOR BIOL
BIOL-398	COOP EDUC
	Credit/No Credit
BIOL-416	MOLECULAR GENETCS
CHEM-301B	ORGANIC CHEMISTRY
CHEM-302A	ORGANIC CHEM LAB

	AHRS	EHRS	QHRS
Current	18.00	18.00	17.00
Cumulative	180.00	180.00	37.00

NO ENTRY BELOW THIS LINE

001022200

Transfer Credit Applied to Spring Quarter 1993
SUPPLEMENTAL HIGHER ED CREDIT 12.00

Spring Quarter 1993

BIOL-422	VERTEBRATE STRUCT+FUNCT
BIOL-424	GEN EMBRYOLOGY
BIOL-440	TAXON ANGIOSPERMS
CHEM-301C	ORGANIC CHEMISTRY
CHEM-302B	ORGANIC CHEM LAB
MATH-206	CALCULUS I
	Advanced Placement

	AHRS	EHRS	QHRS
Current	22.00	22.00	18.00
Cumulative	214.00	214.00	55.00

Spring Quarter 1994

NTRS-300	PHYSIO+NUTR BASES OF FITNESS
RELS-345	HLTH+WELLNESS WORLD RELIGIONS

	AHRS	EHRS	QHRS
Current	8.00	8.00	8.00
Cumulative	222.00	222.00	63.00

Requirements completed for Bachelor of Science
End of Baccalaureate Academic Record

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED, PROHIBITS RELEASE OF THIS TRANSCRIPT INFORMATION TO A THIRD PARTY WITHOUT WRITTEN CONSENT OF THE STUDENT.

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[redacted]

Anthony Joseph Garcia [redacted]

PAGE: 1 OF 1
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Issued to Student

THIS DOCUMENT HAS A MICROPRINT BACKGROUND. DO NOT ACCEPT WITHOUT

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
5151 STATE UNIVERSITY DRIVE, LOS ANGELES, CA 90032

Anthony J. Garcia

Student ID: [redacted] Birthdate: [redacted]

Official Baccalaureate Academic Record

Secondary Schools:
High School Graduation Date — Graduated Jun 1991

Higher Education Institutions:
UC Davis — Sep 1983 - Dec 1983
CSU Los Angeles — Jun 1992 - Sep 1993
Mt San Antonio College — Jun 1988 - Jun 1992
CSU Cal Poly Pomona — Jan 1991 - Jun 1992
Prelim Last 90

Degrees Awarded:
Bachelor of Science — Jun 11, 1994
School of Natural & Social Sciences
Major: Biology

Transfer Credit:
HIGHER EDUCATION CREDIT: 136.00

Summer Quarter 1992

BIOL-410 EVOLUTION
BIOL-499 UNDRGRD DIR STUDY
Credit/No Credit

	AHRS	EHRS	QHRS
Current	8.00	8.00	4.00
Cumulative	144.00	144.00	4.00

Fall Quarter 1992

BIOL-360 GENERAL ECOLOGY
BIOL-398 COOP EDUC
Credit/No Credit
CHEM-201 QUANT ANALYSIS
CHEM-301A ORGANIC CHEMISTRY
SOC -425 MEDICAL SOCIOLOGY

	AHRS	EHRS	QHRS
Current	18.00	18.00	26.00
Cumulative	162.00	162.00	30.00

Winter Quarter 1993

BIOL-330 CELL BIOLOGY
BIOL-357 WRITING FOR BIOL
BIOL-398 COOP EDUC
Credit/No Credit
BIOL-416 MOLECULAR GENETCS
CHEM-301B ORGANIC CHEMISTRY
CHEM-302A ORGANIC CHEM LAB

	AHRS	EHRS	QHRS
Current	10.00	10.00	17.00
Cumulative	180.00	180.00	47.00

NO ENTRY BELOW THIS LINE

001022199

Transfer Credit Applied to Spring Quarter 1993
SUPPLEMENTAL HIGHER ED CREDIT 12.00

Spring Quarter 1993

BIOL-422 VERTEBRATE STRUCT+FUNCT
BIOL-424 GEN EMBRYOLOGY
BIOL-440 TAXON ANGIOSPERMS
CHEM-301C ORGANIC CHEMISTRY
CHEM-302B ORGANIC CHEM LAB
MATH-206 CALCULUS I
Advanced Placement

	AHRS	EHRS	QHRS
Current	22.00	22.00	18.00
Cumulative	214.00	214.00	55.00

Spring Quarter 1994

NTRS-300 PHYSIO+NUTR BASES OF FITNESS
RELS-345 HLTH+WELLNESS WORLD RELIGIONS

	AHRS	EHRS	QHRS
Current	8.00	8.00	8.00
Cumulative	222.00	222.00	63.00

Requirements completed for Bachelor of Science
End of Baccalaureate Academic Record

[illegible] 1974, AS AMENDED, PROHIBITS RELEASE OF THIS TRANSCRIPT INFORMATION TO A THIRD PARTY WITHOUT WRITTEN CONSENT OF THE STUDENT.

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Anthony Joseph Garcia [redacted]

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ACADEMIC RECORD